



Money Follows the Person

Referral Form



Date: _____

Referred By: _____

Agency: _____ Phone Number: _____

Name of Person Referred: _____ Phone Number: _____

Date of Birth: _____ Age: _____

Institution/Nursing Home: _____

Address: _____

City/Zip: _____ County: _____

Contact Person: _____ Phone Number: _____

Admission Date to Nursing Home: _____

Anticipated Referral CCSP ☐ SOURCE ☐ ICWP ☐ Date Referred: _____

Currently on wait list for: CCSP ☐ SOURCE ☐ ICWP ☐

Letter or contact info from the waiver: Yes ☐ No ☐

Case Manager if assigned _____ Phone Number: _____

Interested Parties:

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Pertinent Information:

Money Follows the Person (MFP)

Department of Community Health
Medicaid Division, Aging & Special Populations
2 Peachtree St. NW, 37th Floor
Atlanta, GA 30303

Website: dch.georgia.gov/mfp

Email: gamp@dcg.ga.gov

Phone: 404-656-6862